CLIENT ID # _____

PATIENT'S ELIGIBILITY RECORD

TODAY'S DATE _____/_____/_____

DMV/AIN/SSN _____/_____/_____

DATE OF BIRTH _____/_____/_____

NAME _____
LAST **FIRST** **MIDDLE NAME**

FAMILY SIZE _____

INCOME STATEMENT*

SSN/AIN NUMBER	CONTRIBUTOR'S NAME	INTERVAL	VERIFICATION AMOUNT SOURCE (ATTACHED)	GUARANTOR

*** Always provide documentation for determining eligibility classification.**

Annual Total Income $ _____

Sliding Scale Multiplier _____

Eligibility Date _____

Completed by: _____

04/99 (ELIGIBFORMVISION.11)